(Serve you.)

CUSTOM Rx MANAGEMENT

Prior Authorization Request

Submit this completed form via:

Fax: **800-480-4840**, Attention: Authorizations
OR
Mail: Serve You, Attention: Authorizations
10201 W. Innovation Drive, Suite 600
Milwaukee, WI 53226
OR
Email: **priorauthorizations@serve-you-rx.com**

For questions, please call **800-759-3203**

SECTION I – GENERAL INFORMATION		
Patient Information	**Prescriber Information**	
Patient Name:	Prescriber Name:	
Member ID:	NPI:	Specialty:
Address:	Address:	
City, State, ZIP:	City, State, ZIP:	
Date of Birth:	Telephone Number:	Fax Number:

SECTION II – REQUESTED MEDICATION		
Name:	Strength:	Frequency:
Expected duration of therapy:	If this is a continuation of therapy, provide start date:	

SECTION III – CLINICAL INFORMATION		
Diagnosis:	*Diagnosis code (ICD):*	*Date of diagnosis:*
List all medications the patient has previously tried and failed for treatment of this diagnosis including reason(s) for discontinuation and provide all relevant clinical documentation that supports use of this medication. If a continuation of therapy, provide documentation of clinical improvement or significant clinical response.		
☐ **Urgent** Review Requested		

Prescriber Signature: _____ Date: _____

Certain prescription benefit plans or situations may require additional information or clarification to evaluate a prior authorization request. For complete details about benefits, limitations, conditions and exclusions, please refer to the applicable plan.